STATE

DEPARTMENT of Public Welfare

Office Memorandum

TO : Vera Likins, Commissioner

DATE: June 3, 1975

FROM : Roland M. Peek
Bruce C. Libby
Office of Research and Evaluation

SUBJECT: Minnesota Developmental Programming System (MDPS)

This is in response to Wes Restad's memo of May 14. In arriving at your decision regarding the state-wide adoption of the MDPS we feel that serious consideration should be given to the comments made by several MR program directors, which were attached to Wes's memo, since these opinions reflect long experience in the assessment and treatment of retarded persons. Bob Bader's memo, in particular, thoughtfully presents several issues and questions, many of which are also expressed by others, notably Dale Offerman, Anne Swanson and Ken Stinson.

First, there are several questions centered around the possible uses of the data -- population description, individual program planning, and program evaluation. As these knowledgeable people note, any given instrument cannot adequately perform all of these functions for all of the various people who are called retarded. If one of the reasons for periodically collecting standard information is to describe the MR population, then the use of the MDPS is, in our opinion, inappropriate. Adequate population description could be achieved by the inclusion of five to ten categorical items in POIS. As Ken Stinson vigorously points out, if individual assessment for program planning is the purpose, then there are many reasons not to make a particular method mandatory. In other assessment situations, the exclusive use of a single instrument derives from its demonstrated worth over years of professional practice and/or experimental research, not from administrative policy. In this regard, to our knowledge no reliability or validity information on the MDPS has been published. When agencies need to exchange detailed behavioral information about a resident, which Wes indicates would be a primary reason for universal usage of MDPS, then the professional persons concerned with that case should determine what, if any, instruments will be most effective. The use of such checklists as the MDPS for program evaluation, by such methods as comparing "before" and "after" scores, is completely unacceptable in the absence of rigorous reliability and validity data. Whatever the reasons for the collection of standard information, these should be made clear to the institutions before it is collected.

75-MDP-RMP

Second, there were expressed concerns with costs, data processing, program planning procedures, research and development, and compliance with Rule 34 requirements. As with the data utilization questions, these questions should be explicitly answered before the system is adopted. The institutions should know what "the system" is before they buy it.

Finally, several of the institutional comments indicate the view that there is an MDPS vs. ABS issue. As far as we are aware, the ABS has been discontinued due to lack of sufficient central office support, so there is no such issue. Nevertheless, it is worth noting that all of the above comments would also apply to the ABS, or to any standard instrument or system, and it is largely because these same questions were not adequately dealt with before the ABS was adopted that its administration became a colossal fiasco.

RMP;BCL:pl

cc: Executive Staff

STATE OF MINNESOTA

DEPARTMENT of Public Welfare

Office Memorandum

TO : Vera Likins

DATE: May 14, 1975

Dr. Peek

FROM : Wes Restad

SUBJECT: Minnesota Developmental Programming System

At an earlier Executive Staff meeting the above was discussed in the context of a "proposal" to adopt the Minnesota Developmental Programming System as the primary and/or "base" system we would use and/or advocate for use within the state hospitals and community. Following our discussion I was asked to "poll" the eight state facilities which program for the retarded to ascertain reactions to the proposal. The attached are copies of written responses I have received from six facilities:

Brainerd
Cambridge
Hastings
Moose Lake
Rochester
Willmar

At our last CEO meeting I was advised that the following campuses support the adoption of the Minnesota Developmental Programming System as our primary-basic assessment instrument:

Faribault
Cambridge
St. Peter (MVSAC)

The Fergus Falls campus supports the adoption of the Minnesota Developmental Programming System but wishes to evaluate further the usefulness of the ABS as well as its compatibility with the Minnesota Developmental Programming System before "abandoning" the ABS.

NOTE: I have authorized Fergus Falls State Hospital to continue to use ABS in addition to the Minnesota Developmental Programming System for this year's assessment. In so doing, it is understood that Fergus Falls State Hospital will not expect any help from Central Office reference ABS.

RECOMMENDATION:

I do not wish to stifle creativity and/or imaginative use of diagnostic and/or assessment instruments. At the same time, however, I'm satisfied that if we are to develop and sustain appropriate programs for the developmentally disabled we have to support the development of an instrument which will have common usage, common language, etc., to facilitate exchange of information within and between both private and public sectors. Accordingly, I recommend that DPW announce that the Minnesota Developmental Programming System is the basic and/or primary

system that we support. To facilitate collection of data (both public and private), to facilitate the exchange of information (both public and private) that we (Central Office) effect a system-wide expectation that the Minnesota Developmental Programming system be used.

In stating the above, it is in the context of a minimum expectation. Hence, if a given campus-private agency, etc., wishes to use additional assessment instruments, devices, procedures they are free to. Recognizing that it is (or will be) common knowledge of what our minimum expectations are.

WGR:mhv (Transcribed May 16, 1975)

Attachments

CC: Executive Staff

STATE OF MINNESOTA

DEPARTMENT Brainerd State Hospital

Office Memorandum

TO : Mr. Harold S. Gillespie
Chief Executive Officer

DATE: 5/2/75

FROM : Robert F. Bader
M.R. Division Director

SUBJECT: ABS - Minnesota Developmental Programming System
Mr. Restad's Memo #28, dated April 11, 1975

In reviewing Mr. Restad's proposed memo regarding the Adaptive Behavior Scale and substituting the Minnesota Developmental Programming System assessment instrument, a number of questions are raised relative to how the Department plans to use the information. As an instrument to be used statewide to sample behaviors for retarded persons at a given point in time, it does have value. If the instrument is to be utilized for program assessment, or to measure program effectiveness, then the instrument has many serious gaps, especially for the population at Brainerd State Hospital. There appears to be general consensus among the staff that, for the population at Brainerd, the bottom of the scale is not sufficiently low and that the steps between scale items are toowide to measure progress on a yearly basis. If the Department chooses to require this assessment instrument on an annual basis for all residents, we will do this and provide the information. However, for purposes of individual program planning, we plan to continue to use a variety of instruments. We currently use the Compet in conjunction with the local public school, the Brainerd Rating Scale, and the Adaptive Behavior Scale as the major instruments for program planning purposes.

The deleting and dropping of the ABS because of problems in processing through the computer is not a valid argument for the Department to utilize to substitute the MDPS assessment instrument. The reason I say this is that at the present time we are scoring and providing the information and data on the revised ABS to the units without the use of a computer. The revised ABS lends itself to either computerization or hand scoring, to an equal degree with MDPS. Our judgments on the MDPS assessment instrument are based on copies that were sent to us and the one which the staff were trained in, in January, 1975. It is our understanding that minor revisions were made to this instrument; however, we have not seen them as they are at the printer's and they are not available to us for the present. It is our understanding that the revisions are relatively minor and, therefore, would not substantially change our concerns for this instrument and how it is to be used.

The other part of the Minnesota Developmental Programming System consists of forms for writing goals and program objectives for the resident. This part of the system contains ideas which staff in the MR Division are recommending that we incorporate into the program planning system at Brainerd State Hospital. The Program Plan system of MDPS does not address itself to all of the requirements of items to be covered in our provisions for Rule 34, nor does it address the incorporation of the ICF-MR Health Plan requirements. We feel very strongly that the individual program plan for a resident must be a single plan developed by the unit and should not be set up and identified as separate programs.

There are additional questions that I have relative to the MDPS system. These are: 1) What will the cost of the assessment scales be to us, as these appear to be copyrighted by the University of Minnesota and will be published, apparently, by them. 2) What format for computer information will be available to us, and at what cost to us? 3) Is the system committed to do research to develop norms and scale revisions in reference to the system package? 4) Will all facilities be required to utilize the system format and forms as published, or will we be able to modify the system and adapt it for use here? 5) Will the Rule 34 surveyors be using MDPS to define what they believe are the most important training areas, which may be in direct conflict with staff concerns or staff plans, such as-- we were recently told that training a resident not to run away is more important than, say, toilet training. I would like to discuss this more with you and clarify some of the items in this memo.

RFB/m

STATE OF MINNESOTA

DEPARTMENT Cambridge State Hospital

Office Memorandum

TO : Wesley G. Restad, Assistant Commissioner
Bureau of Residential Services

DATE: May 12, 1975

FROM : Dale L. Offerman
Chief Executive Officer

SUBJECT: Memo #28 M.D.P.S.

Per your 4-11-75 memo concerning the adaptation of the Minnesota Developmental Programming System as a state-wide assessment instrument and discontinuance of the Adaptive Behavior Scale System, Cambridge State Hospital is in full agreement with this proposed memo. Of course I might add that initial genesis for this instrument occurred at our facility and our staff have continued to be involved in its development; thus, we are somewhat biased in terms of adapting it.

Your memo was circulated to various program services staff for feedback and it received positive endorsement. However, it is hoped that in adapting the M.D.P.S. that we are only agreeing to use the assessment part of the system, rather than the complete package. Our staff feel that Cambridge State Hospital is quite a bit ahead of the program planning sections and evaluation areas.

Our next question is when will the assessment be printed and available, what is its cost, and is the state anticipating covering this cost. We sincerely hope the system will provide the type of rapid feedback that was originally intended under the A.B.S.

Incidently, concerning the A.B.S., we probably will continue to use the Part II - Maladaptive Behavior section for certain selected residents in our Mental Health Treatment areas. However, we do not wish to lock this part of the assessment into any state-wide system.

DLO:cr

D. L. Offerman

STATE OF MINNESOTA

DEPARTMENT HASTINGS STATE HOSPITAL

Office Memorandum

TO : Mr. Wesley G. Restad, Assistant Commissioner
Residential Services Bureau

DATE: 9 May 1975

FROM : Mr. James E. Brunsgaard
Chief Executive Officer

SUBJECT: Minnesota Developmental Programming System

The following are comments from our staff who work with the retarded on our Residential Opportunity Center concerning MDPS:

"In looking over the Minnesota Developmental Programming System, we feel it has greater possibilities than the ABS. It appears to stress the positive things about the person.

Since our program is phasing out (at last notice), we do not feel we would use it, but it would be of value for a program such as ours.

However, we want to state that the system cannot be implemented without extensive inservice and additional program and resident living staff.

We have, for too long, tested our persons but never have found resources or the time necessary to teach what the person needed. A test is of no value unless something results from it. The person must be taught what the test indicates he needs.

We are assuming appropriate revisions will be made as needed on the M.D.P.S."

I agree that resources must be made available to provide the training that is indicated by the testing. Knowing what is needed is extremely frustrating when resources are not forthcoming to provide that training.

/emr

DEPARTMENT Moose Lake State Hospital

Office Memorandum

TO : Wesley G. Restad
Assistant Commissioner
Residential Services Bureau

DATE: May 7, 1975

FROM : Harvey G. Caldwell
Chief Executive Officer

SUBJECT: Memo #28

Attached is the response you requested in the above-referenced memo regarding the ABS--Minnesota Developmental Programming System.

HGC:jw

DEPARTMENT SRC

Office Memorandum

TO : Mr. Caldwell

DATE: 5/6/75

FROM : Anne Swanson

SUBJECT: Restad - Memo #28

Generally our impressions, through experience, with the Minnesota Developmental Programming System are positive. We are primarily using the assessment tool and not the total package system. Our current program plans parallel the instrument with a more expansive sub system of baselining. This has helped us fill the gaps and develop scales below the assessment tool. It just doesn't reach low enough for some residents. There also remain some problems at the upper end of some of the domains.

The projected feedback systems sounds good but we feel we need some additional clarification on how it can best be used - turn around time, etc.

Since there are as many systems as there are people to put them together, any or all are generally usable. Each has assets and failures. Will it meet the Rule #34 requirement? If so, we have no strong objections. Just that right now we would like to have someone say this is it, fly with it, so we can get on with programs for individual residents.

One additional comment - I'm not as sure that all of our community facilities are that happy with it. We have had several requests to fill out the ABS form when getting a resident ready for discharge. This is probably related to the shortcomings at the upper end of the scale.

AS:jw

STATE OF MINNESOTA

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Office Memorandum

• DEPARTMENT Rochester Social Adaptation Center

TO : Wesley Restad, Asst. Commissioner
Residential Services Bureau

DATE: April 24, 1975

FROM : Dr. Francis Tyce, Chief Executive Officer
Rochester State Hospital

SUBJECT: ABS-Minnesota Developmental Programming System

I have discussed your memo regarding ABS and Minnesota Developmental Scale with the staff at RSAC. They are in agreement to eliminate the ABS. They are currently waiting to receive copies of the Minnesota Developmental Scale which they have reviewed to implement in their Center as a diagnostic assessment instrument in terms of program planning which also should meet JCAH standards. They are anxious to start this at RSAC as they will be reviewed again next year by JCAH.

It is also felt that it would be wise to make the Minnesota Developmental Scale statewide which should be a great asset in transfering retarded from one facility to another and as stated in the memo, provide a common set of principles, definitions, etc. to all working with disabled people.

We support adopting the Minnesota Developmental Scale. Let's start soon!

FAT:sr

cc Mrs. Barbara Thompson
Acting Director - RSAC

STATE OF MINNESOTA

DEPARTMENT Willmar State Hospital

Office Memorandum

TO : Wesley G. Restad, Assistant Commissioner
Residential Services Bureau

DATE: May 8, 1975

FROM : Lester E. Johnson, Administrator

SUBJECT: ABS and Minnesota Development System

I referred your memo to Mr. Stinson for advice and suggestions on how to reply. Obviously I did this since I am not an expert on this subject.

In short, I am attaching Mr. Stinson's reply to me for your use as you see fit. In discussing the subject I can see the merit of what Mr. Stinson says. In effect, he warns against getting locked into using a single measuring device whereas in the field of general psychological testing we do not limit ourselves to one instrument.

LEJ:pk
Encl.

STATE OF MINNESOTA

DEPARTMENT GRTC

Office Memorandum

TO : Lester Johnson, Chief Executive Officer DATE: 5-6-75

FROM : Ken Stinson, Program Director

SUBJECT: ABS & the Minnesota Developmental Programming System

Les, you asked me some time ago for our comments concerning the use of the Minnesota Developmental Programming System as requested by Mr. Restad in his memo of April 11, 1975.

I will attach them to this particular memo since I am not sure as to whether or not you prefer to send those comments directly to Mr. Restad or perhaps combine them with comments of your own.

KS/cl

Enclosure

STATE OF MINNESOTA

DEPARTMENT OMRC

Office Memorandum

TO : Lester Johnson, Chief Executive Officer

DATE: 5-6-75

FROM : Ken Stinson, Program Director

SUBJECT: Minnesota Developmental Programming System

The Minnesota Developmental Programming System is undoubtedly a valuable addition to the gamut of available instruments which are available and useful in dealing with the severely and profoundly retarded. We personally feel it as certainly an improvement over the Adaptive Behavior Scale; however, feel it is very important to stress that the scale is only one of several scales, including the Vineland Social Maturity Scale, Adaptive Behavior Scale and a wide variety of other behavioral scales which are available. Each scale, obviously, has its' own strengths and weaknesses and these often vary depending on the nature of the setting, the severity of the retardation, the nature of additional physical handicaps, etc.

It is my believe that Minnesota would be making a very drastic mistake to lock itself into any single diagnostic instrument and make that instrument mandatory. I say this for a number of reasons;

(1) Instruments have a way of becoming obsolete and sometimes within a very short period of time.

(2) Our system, nor any other that I am aware of, does not adopt a single I.Q. test as a diagnostic instrument and consequently I would question the wisdom of adopting or locking ourselves into a single behavioral diagnostic instrument.

(3) I am not sure why it is necessary to "make everyone the same." In fact, I still shudder with fear when I see how close we came to being locked into the ABS as a single system and still shudder with anger at the waste which the particular fiasco engendered.

(4) It seem to me that multiple strategies are inherent to a developing system and that to adopt any single common diagnostic instrument may well stifle further progress.

I do understand; however, the law that all facilities are obligated to assess annually. Nevertheless, I would suggest that this same thing might well be better accomplished by the following suggestion;

That residential services, Comprehensive Programs and/or Licensing Division put together a list of approved assessment instruments, both these that are currently in use and also allow each facility to adopt or develop a different scale which they could submit for approval. This would, I believe, fulfill the requirements for annual assessments but at the same time allow for future growth, expansion, experimentation, and refinement of assessment instruments.

Hope these comments are of some assistance.

Thank you. Ken Stinson

KS/cl